MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, December 13, 2001
10:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

Agenda item:
Public comment I

MR. HACKBARTH: Now we will open our public comment period. Please, we've got a limited amount of time available, namely 15 minutes. Please keep your comments brief. And if you hear somebody before you make the point you were going to make, why don't you consider it made and we'll move on.

MR. GREENBERG: I'm George Greenberg and I work in ASPE, Assistant Secretary for Planning and Evaluation, at HHS. I had a couple of thoughts, I hope these are factual.

I don't believe the 2006 year simply because that add-on is $1.4 billion, I think, and we're under a lot of budgetary pressure to do something by next October. Whether that actually happens or not, given the ability to do intelligent refinement in this area, I'm not exactly sure. But I just want to point out as a fact that the administration is looking at that money and wants the Department to make the change. And there are people in the Department who want to make it, too.

Another point about 2006 is the Department is also working on an integrated post-subacute care payment system and I would hope that by then we're not talking about all these different stovepipes of separate reimbursement systems, but we may have assessment instruments and others that look across the entire sub-post acute area and it may be a different discussion by then. So you may want to think about that.

I want to reinforce the comment that where did all these SNF patients go? I think the idea of looking -- I think Sally made it -- of looking back at people staying in the hospital longer should be examined because if that is what is going on I think it's a good thing. 20 years ago we were all upset about administratively necessary days so we developed all of these separate post acute care payment systems and everyone cost administratively necessary days at the average cost of a hospital stay. They don't cost the average cost.

First of all, you've already paid for a lot of it under the DRG. So if there's someone an extra day it's already paid for, an extra two days. Secondly, you're basically paying for room and board services, hospital services. You're not using a lot of technical hospital technology. And if someone actually needed subacute care, they're in an acute care setting. So maybe the care is better. That all needs to be looked at, I think, as part of the financial picture.

The last comment is I just want to reinforce the discussion that Jack made in response to Bob's point about whether hospital-based care is appropriate. It seems to me although there were a lot of crazy incentives in the '90s, that you had to be crazy not to create a distinct port SNF if you were a hospital because you basically were under cost reimbursement and you could unbundle from the hospital inpatient payment and make more money. There are a number of clinical reasons, as people said, but you want to encourage integrated care. You want to encourage people who are in the high case mix end of being in an appropriate setting. And I think you reduce transfer trauma if the patient is not being moved across institutions and if hospital inpatient capacity, if we really are over-bedded, it's potentially a good use of the beds.

As I listened to the discussion all of these thoughts came into my head. I just thought I'd try and share some of them.

MR. LAZARUS: Good afternoon. I'm Barry Lazarus and I'm vice president of reimbursement with Manor Care in Toledo, Ohio. I'm representing American Health Care Association.

I'd just like to remind the commissioners that there's over 10,000 proprietary facilities in the United States. They account for 66 percent of all care provided in SNF beds. That equates to about 1 million patients per day that are cared for in the proprietary setting. So we need to understand and put in perspective that there is an issue with the proprietary setting.

The analysis that the MedPAC staff prepared, I don't believe, presents a good picture of the industry. It's misleading and it's potentially catastrophic in its conclusions. Using this analysis to make recommendations to eliminate the relief that was provided by the Balanced Budget Act and the Budget Improvement and Protection Act really will have a negative and traumatic experience to an already fragile component of our health care delivery system.

The decrease in the payments at this time would really have a dire consequence to the patients that we provide. Many of those patients may be your family members or people that you know. It really will not be a short-term problem. It will be an ongoing problem for many years to come.

We believe, first of all, that the analysis is flawed. It's flawed from the standpoint of the cost report information that was presented after the establishment of PPS is not reflective of the true cost of providing care.

As we moved into the SNF PPS, priorities changed within the facility of having our nursing staff track their costs, track their time in spending services in distinct parts and non-distinct parts, having other statistics maintained. And we've focused our energies on doing a better job, a more complete job in the additional burden of the MDS process and the additional assessments that we had to complete.

Secondly, when you look at a Medicare-only margin, it really misrepresents what's happening within our industry. We're extremely concerned about the body of this financial analysis that ignores the viability and the problems of the industry that we've been encountering. As you probably know, five out of the seven long-term care companies are in bankruptcy. Some are starting to come out of bankruptcy.

But you also need to understand, and I think someone mentioned, the equity markets. The equity of our industry from 1998 to the first quarter of this year has decreased by 75 percent. The stock market doesn't like what's happening with the SNF industry and there's major concerns.

In addition, the analysis and conclusions do not consider a lot of facts. One is that the market basket only accounted for about 40 percent of the actual cost increases incurred. As the staff uses that market basket update to project costs forward, it's truly understating what the impact of these cost increases will be into the future.

This, coupled with the continued increases in labor costs that we're seeing, mandated staffing requirements in various states such as Florida and Ohio, and liability costs, the prospect of Medicaid budget cuts due to the economy, the single payer analysis doesn't really portray what's happening.

We believe that the evaluation of the hospital PPS system did, in fact, in the past look at the broader financial perspective of the hospital industry, did take into account the other payers. And Medicare's financing role must be examined within the larger context of the overall payment system. And the inadequacies of not only the Medicaid system but other payers, such as managed care, VA, and to some extent private pay.

Finally, our analysis caused the problem recommendation to utilize a different base for hospitals. As you know in the BBA, Congress decided that the cost of hospital-based units were overstated. They established the basis of limiting 50 percent of the difference between the hospital-based and freestanding costs and they decided that the rates should be paid based upon the patient acuity irregardless of the site.

So now we're talking about going back to a system where there was a differentiation and that the hospital unit cost is greatly overstated. While there may be some arguments to the acuity, we believe that in freestanding SNFs any level of acuity can be provided. Prior to PPS there was what we called subacute care, and we provided a high level of services in the freestanding environment due to changes in delivery systems, due to changes in technology.

The other thing that you all have to consider is the fact that we're working with HHS to develop this quality initiative. If payments are cut, if the add-ons are allowed to sunset, there could be a real impact on the quality of services not only to the Medicare beneficiaries but to all the people that we provide services to.

So I'd like to just ask MedPAC to consider the stability of the industry and concern itself with the adequacy of the payment and overall industry margins and the access of capital. The payment system must be adequate to provide an appropriate level of quality and access to services that can be provided by an efficiently operating facility and should really make no distinction based on the location.

Again, thank you.

MR. LANE: Larry Lane, I'm vice president of Genesis Health Ventures.

Essentially five quick points. I'm really concerned that the Commission may be basing its actions on some incomplete data and analysis with grave consequences. First off, hospital-based provide only 14 percent of your Medicare days. I do have an analysis that I'd like to share with the Yuden-Oscar data that basically breaks out numbers and percentage of nursing home patients by payer sorts, et cetera.

Second, data. The 1999 cost report file is flawed. We have had great trouble using it. We have brought that to Commission staff. I know they have made some adjustments in what they've done with it. But the truth of the matter is we cannot come out with meaningful analysis using the '99 data.

But we have looked at though, interestingly, the '95 which is your base year data. Your base year data basically points out that you have a significant bimodal distribution of days. You have 48 percent of the days at $183 a day and 52 percent of the days at $378 a day.

So essentially, looking at that, when you go to an average payment structure you immediately see there's going to be obvious winners and losers. But what doesn't come out in that analysis until you deep dive is what services were they providing and what were the cost of those services?

So essentially we have a payment structure where a margin analysis has been put out using cost data that's flawed without asking the underlying questions of what services are included or not included in that, and which blends this bimodal distribution across your facilities. And that explains why 1,000 to 1,800 facilities went bankrupt at the same time that there may be 4,000 to 5,000 facilities that had an improvement in their margins in the averaging.

And then finally the point that Barry picked up on is that you cannot just look at Medicare. The real issue here and the travesty is that 75 percent of the residents in nursing homes are paid for by the public sector. And that accounts for 60 percent of the revenue. Medicare is not the driver, Medicaid is the driver. But changes in Medicare at this point, without looking back through at what is delivered, what were the products, and what patients got the service, would in fact destabilize this sector. And I would point out again, 65 percent of your Medicare days are provided by investor-owned, 84 percent by freestanding facilities, or 86 percent by freestanding facilities.

There's a lot at stake that if we destabilize the sector again, we may significantly disrupt the service delivery structure.

MR. ELLSWORTH: Good afternoon. My name is Brian Ellsworth. I'm with the American Hospital Association, representing about 2,000 hospital-based SNFs and another 1,250 hospitals with swing beds who will also be affected by the decisions you make here.

Let me say a couple of things.

One is length of stay is a key factor here. Our Medicare length of stay for hospital-based SNFs is about half of what the freestanding length of stay is. And so as a result, when you hear a statistic like we care for 14 percent of the days, we actually care for about close to 30 percent of the cases. And that's pretty significant. And that's because our length of stay is shorter, so we're getting the outcome in half the time, which has very specific cost implications. When you're looking at a per diem system it's going to stand to reason that your costs are loaded higher in a per diem system. But if you look at it on a cost per case basis, our costs are actually significantly lower.

So I would encourage that as one of the avenues that you look at when you're designing the blunt instrument.

The second point I'd make is as you look to refining the system, one of the problems with that -- and we're all for refining the system. But the way the statute is constructed, the refinements giveth and then the statute taketh away the add-ons. That's roughly a washout, at least from our perspective.

So it's not much help. Unless that statutory structure is examined and reconsidered, that refinement by itself just adds money and then takes it away.

Thirdly, swing beds, it was mentioned that they would be advantaged by this. Again, that is with the two add-ons that are scheduled to sunset next year in there, they would be -- according to CMS analysis -- about an 8 percent winner. With those two add-ons taken away they would actually go in the red. So I just thought that that would be important to consider as you're looking at rural access issues.

And finally, I'd make the point that the rates are pretty clearly compressed from a case mix standpoint. The refinement proposal that CMS put forward a year ago pretty clearly indicated that there was a fair degree of compression. The rates that they proposed were much more stretched out than the rates that are current, even with the add-ons. So that is an additional piece of evidence that you should look at that is, I think, very confirming of the analysis that you did with the APR DRGs that both indicate the same kind of magnitude of compression on case mix, particularly underpaying those facilities taking care of medically complex patients.

We're more than willing to work with you to help design how this system should be rectified and I just wanted to make those points in doing so.

Thank you.

MS. CARLINO: Hello, I'm Beth Carlino. I'm representing NASPAC, the National Subacute Association. I'm also a rural health care hospital-based facility provider.

I'm going to say amen to most of the people who spoke before me and take my cue from saying that I'm not going to repeat everything that was said, but I certainly would agree with most of what was said by my colleagues prior to this.

I would like to remind the panel here that initially when the PPS system was initiated it was called PPS, but truly we don't have an episodic payment. So since we don't have an episodic payment, we really don't understand what our costs are per beneficiary per episode of care, because we've got this disjointed system that pays on a daily basis instead of an episodic basis.

So in order to measure things like how much did it cost, are we effectively having good outcomes with that cost, the system doesn't allow us to do that. So to keep throwing money at it and to keep trying to adjust what we currently have is simply not appropriate and I would like to indicate that, in fact, the whole system of RUG determination needs to be not adjusted but completely restructured.

The other indication that I'd like to say is that the MedPAC and the Abt study indicated that those systems for payment and reimbursement were flawed. I would just suggest for you that before you determine without adequate information about this episodic payment that you do away with the sunset regulations. You consider the fact that you don't know what the episodic payment and the decreases to that payment are going to really do to the entire industry. And so until you have that information, my suggestion would be that, in fact, we keep those add-ons and keep those dollars because we've already exceeded the mandated amount that initially was required by the government to save in this industry.

I agree that the burgeoning costs and the escalating costs of 26 percent each year were inappropriate. However, to have taken more than what was mandated away, putting this additional money to it was not burdensome to the establishment.

MR. VERTRASE: Hi, my name is Jim Vertrase. I'm with the 3M company. Just for those who don't know, in addition to Post-it notes and Scotch tape, 3M makes most of the case mix measurement tools that are used around the world.

We have been looking at the issue of creating a case mix measurement system for skilled nursing facilities. I think it's a feasible task.

Our basic philosophy in creating case mix tools is to first create a tool that's useful for management. If you do that right, it will be useful for payment as well. We're confident we can build a system that's admission-based, that's episode-based, that's severity adjusted, that's based on -- for the classification and the severity levels both -- are based on diagnosis, the principal and secondary diagnoses, as recorded upon discharge from the hospital.

That strategy minimizes provider burden. We would make little use of ADL-IDL information, using that to augment diagnosis information only if it and as needed --

MR. HACKBARTH: Excuse me. This is important information, but this probably isn't the best way to convey it. So I think it would be more effective if you could share your ideas with the staff and then we can consider it at an appropriate time. This is a problem we're not going to solve today but it's still one we're interested in. So by all means, share your information.

MR. VERTRASE: I'll do that. Thank you.

MR. HACKBARTH: We've got to adjourn right now. We reconvene at 1:15.

[Whereupon, at 12:32 p.m., the meeting recessed, to reconvene at 1:15 p.m., this same day.]